Arkansas Department of Human Services
Division of Medical Services
Donaghey Plaza South
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Little Rock, Arkansas 72203-1437
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Telephone: (501) 682-8292 TDD: (501) 682-6789 or 1-877-708-8191 FAX: (501) 682-1197

OFFICIAL NOTICE

DMS-2002-AR-10	**DMS-2002-I-6**	**DMS-2002-FF-3**	**DMS-2002-Y-7**
DMS-2002-C-4	**DMS-2002-L-15**	**DMS-2002-R-18**	**DMS-2002-YY-7**
DMS-2002-F-2	**DMS-2002-KK-14**	**DMS-2002-EE-6**	

TO: **Health Care Provider – ARKids First-B; Child Health Management Services (CHMS); Developmental Day Treatment Clinic Services (DDTCS); Home Health; Hospital; Nurse Practitioner; Occupational, Physical, Speech Therapy; Physician; Podiatrist; Rehabilitative Hospital and Rehabilitative Services for Persons with Mental Illness (RSPMI)**

DATE:

SUBJECT: **Revision of Form DMS-640 – Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients under Age 21 Prescription/Referral**

Effective for dates of service on or after January 1, 2003, Form DMS-640, Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral is revised.

Revision of Form DMS-640 includes the addition of total state fiscal year (July 1 through June 30) expenditures, the average cost per recipient, average units per recipient and total number of recipients served in each of the three covered therapies. This is added to the form to provide the primary care physician (PCP) or attending physician expenditure information.

The revision also includes a statement to be signed by the primary care physician (PCP) or attending physician to certify that a complete review is made of each element of the therapy treatment plan in regard to reasonable and appropriate goals for the patient. For continuation of the treatment plan, the physician's signature certifies that a review is made of the patient's progress with an adjustment of the plan for meeting, or failure to meet, the plan goals.

The PCP must complete and sign with his or her original signature the revised Form DMS-640 (Rev. 1-2003) when prescribing any therapy services. A rubber stamp or automated signature is not acceptable.

An initial evaluation must be prescribed separately from treatment services. The initial evaluation should be reviewed and a customized treatment plan prescribed. Evaluate/Treat will not be accepted as a valid prescription. No prescription should ever have both evaluation and treatment.

Any therapy provider who performs the therapy service must maintain in the recipient's record the original prescription/referral form. The PCP must maintain a copy of the prescription/referral form in the recipient's medical record.

A copy of the revised DMS-640 is attached to this Official Notice.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-8307 (voice) or at (501) 682-6789 and 1-877-708-8191 (TDD).

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at In-State WATS 1-800-457-4454, or locally and Out-of-State at (501) 376-2211.

Thank you for your participation in the Arkansas Medicaid Program.

Kurt Knickrehm, Director
Department of Human Services

Attachment

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: **www.medicaid.state.ar.us.**

Arkansas Division of Medical Services

Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients

Under Age 21
PRESCRIPTION/REFERRAL

The PCP or attending physician must use this form to prescribe medically necessary Medicaid therapy services, or must use this form to make a referral for therapy services. The provider must check the appropriate box or boxes.

☐ Referral ☐ Treatment

EVALUATE/TREAT IS NOT A VALID PRESCRIPTION

Patient Name: _____ Medicaid ID #: _____

Date of Last Physical Examination: _____

Medical Diagnosis: _____

Developmental Diagnosis: _____

Clinical Indication for Treatment: _____

Complete this block, if this form is a prescription		
Occupational Therapy (OT)	**Physical Therapy (PT)**	**Speech Therapy (ST)**
_____Minutes per week	_____Minutes per week	_____Minutes per week
_____Duration (months)	_____Duration (months)	_____Duration (months)

Other Information: _____

_____

_____

Note:

	OT	***PT***	***ST***
Expenditures for SFY02	***$17,848,926***	***$13,648,708***	***$23,455,387***
Average Units Per Recipient	***92***	***89***	***87***
Average Cost Per Recipient	***$1,626***	***$1,536***	***$1,370***
Total Recipients Served	***10,979***	***8,886***	***17,118***

_____ _____
Primary Care Physician Name *(Please Print)* Medicaid Provider Number

_____ _____
Attending Physician Name *(Please Print)* Medicaid Provider Number

By signing as the Primary Care Physician (PCP) or Attending Physician, I hereby certify that I have carefully reviewed each element of the therapy treatment plan, that the goals are reasonable and appropriate for this patient, and in the event that this prescription is for a continuing plan I have reviewed the patients progress and adjusted the plan for his/her meeting or failure to meet the plan goals.

_____ _____
Physician Signature *(PCP or attending Physician)* Date

DMS-640 (Rev. 1-2003)